California Medicine

Owned and Published by the

CALIFORNIA MEDICAL ASSOCIATION
450 Sutter, San Francisco 8
Phone DOuglas 2-0062

Address editorial communications to Dwight L. Wilbur, M.D., and business and advertising communications to John Hunton at the above address.

EDITOR . . . . . DWIGHT L. WILBUR, M.D.

Executive Committee—Editorial Board

LAMBERT B. COBLENTZ . . . . . San Francisco

ALBERT J. SCHOLL . . . . . Los Angeles

H. J. TEMPLETON . . . . . Oakland

GEORGE H. KRESS, M.D., Editor Emeritus

Assistant to the Editor, ROBERT F. EDWARDS

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the tenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . JOHN HUNTON

Subscription prices, $5 ($6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Requests for change of address should give both the old and new address, and should be made by county secretaries or by the member concerned.

Contributions of Scientific and Original Articles:

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. Ordinarily contributors will be notified within 30 days if a manuscript is accepted for publication. Every effort will be made to return unused manuscripts.

Length of Articles.—Ordinarily articles should not exceed 3,000 words (approximately 3 printed pages). Under exceptional circumstances only will articles of over 4,000 words be published.

Manuscripts.—Manuscripts should be typewritten, double-spaced, and the original and if possible a carbon copy submitted.

Illustrations.—Ordinarily publication of 6 illustrations accompanying an article will be paid for by CALIFORNIA MEDICINE. Any number beyond this will have to be paid for by the author.

References.—Should conform to the following order: name of author, title of article, name of periodical, with volume, page, month, day of the month, if weekly, and year—i.e., Lee, G. S.: The heart rhythm following therapy with digitalis, Arch. Int. Med., 44:554 (Dec.), 1942.

Reprints.—Reprints must be paid for by the author at established standard rates which will accompany the author's proof of the article.

"Entered as second-class matter at the post office at San Francisco, under the Act of March 3, 1879." Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 10, 1918.

Leaflet Regarding Preparation of Manuscripts for

CALIFORNIA MEDICINE

This leaflet will be sent to any member of the California Medical Association desiring it.

Contributions of "Letters to the Editor," News and Notes, and Antispasmodics:

The Editorial Board will be glad to receive and consider for publication letters containing information of general interest to physicians throughout the State or presenting constructive criticisms on controversial issues of the day. Also News and Notes items regarding the affairs and activities of hospitals, individuals, communities and local medical societies and groups throughout the State, as well as material in the lighter vein.

California Physicians' Service

Headquarters office of the California Physicians' Service is located at 153 Kearny St., San Francisco 8, Telephone SUtter 1-4633. Los Angeles office located at 743 South Grand View St., Los Angeles 5, Telephone DRexel 5261.

Board of Trustees

Lowell S. Goin, M.D. ..... President
A. E. Moore, M.D. ..... Vice-President
H. Randall Madeley, M.D. ..... Vice-President
Chester L. Cooley, M.D. ..... Secretary
Robertson Ward ..... Treasurer
Ransom M. Cook ..... Assistant Secretary-Treasurer

Donald Cass, M.D.
C. Glenn Curtis, M.D.
J. Frank Doughty, M.D.
Henry L. Gardner, M.D.
A. M. Meads, M.D.
Mr. C. Ray Miller
Rt. Rev. Msgr. Thomas J. O'Dwyer

W. M. Bowman ..... Executive Director
A. E. Larsen, M.D. ..... Medical Director

Administrative Members At Large

Administrative Members of California Physicians' Service are the duly elected Delegates and Alternates to the California Medical Association House of Delegates, together with the Elected Officers and Councilors of the California Medical Association and elected Administrative Members-at-large. The last-named are listed below:

Mr. Lawrence Arnstein
J. Frank Doughty, M.D.
Mr. Jonathan Garst
Lowell S. Goin, M.D.
Alson R. Kilgore, M.D.
Dr. Tully C. Knoles
Mr. Forrest Murdock
Glenn Myers, M.D.
Rt. Rev. Msgr. Thos. J. O'Dwyer
Ernest Sloman, D.D.S.
Mr. Thomas Taylor
Dr. Ray Lyman Wilbur

Officers of the California Medical Association

General Officers

President—John W. Cline, 490 Post Street, San Francisco 2. Garfield 1-1021.

President-Elect—E. Vincent Askey, 2210 West Third Street, Los Angeles 5. Drexel 1254.

Speaker of House of Delegates—L. A. Alesen, 1401 South Hope Street, Los Angeles 15. Prospect 6361.

Vice-Speaker of House of Delegates—Donald A. Charnock, 727 West Seventh Street, Los Angeles 14.

Chairman of the Council—Edwin L. Bruck, 384 Post St., San Francisco 8. Sutter 1-7218.

Vice-Chairman—Sidney J. Shipman, 490 Post St., San Francisco 2. Garfield 1-7164.

Secretary—L. Henry Garland, 450 Sutter Street, San Francisco 8. Sutter 1-7164.

Editor—Dwight L. Wilbur, 490 Post Street, San Francisco 8.

Executive Secretary—John Hunton, 450 Sutter Street, Room 2009, San Francisco 8. Douglas 2-0062.

General Counsel—Peart, Baraty and Hassard, Room 1800, 111 Sutter Street, San Francisco 4. Sutter 1-0861.

Councilors

In addition to the elected district and at-large Councilors, the Council has as ex-officio members the following general officers President; President-Elect; Speaker; Vice-Speaker; and the Association Secretary.

Council Officers: Edwin L. Bruck, Chairman; L. Henry Garland, Secretary.

District Councilors

FIRST DISTRICT—John D. Ball (1950), 414 Spurgeon Building, Santa Ana. Imperial, Orange, Riverside, San Bernardino and San Diego Counties.

SECOND DISTRICT—Jay J. Crane (1948), 1921 Wilshire Boulevard, Los Angeles 5. Los Angeles County.

THIRD DISTRICT—Harry E. Henderson (1949), 1214 State Street, Santa Barbara. Inyo, Kern, Mono, San Luis Obispo, Santa Barbara and Ventura Counties.

FOURTH DISTRICT—Axcel E. Anderson (1950), Medical Group Building, 1759 Fulton Street, Fresno. Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties.

FIFTH DISTRICT—R. Stanley Kneeshaw (1948), 404 Medico-Dental Building, 241 East Santa Clara Street, San Jose. Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties.

SIXTH DISTRICT—Edwin L. Bruck (1949), 384 Post Street, San Francisco 2. San Francisco County.

SEVENTH DISTRICT—Donald D. Lum (1950), 2225 Central Avenue, Alameda. Alameda and Contra Costa Counties.

EIGHTH DISTRICT — Frank A. MacDonald (1948), 822 Medico-Dental Building, 1127 Eleventh Street, Sacramento 14. Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties.

NINTH DISTRICT—John W. Green (1949), Box 539, Vallejo. Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity Counties.

Councilors-at-Large

Walter S. Cherry (1948), 109 N. Riverside Ave., Rialto, San Bernardino County.

H. Gordon MacLean (1948), 230 Grand Avenue, Oakland.

Eugene F. Hoffman (1948), 2212 West Third Street, Los Angeles 5.

Sidney J. Shipman (1950), 490 Post Street, San Francisco 2.

Wilbur Bailey (1950), 2009 Wilshire Boulevard, Los Angeles 5.

C. V. Thompson (1949), 125 South Crescent Street, Lodi.

Standing Committees

Executive Committee*

The President, the President-Elect, the Speaker of the House of delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Secretary-Treasurer (ex officio), and the Editor (ex officio).

Auditing Committee*

Sidney J. Shipman (Chairman)	San Francisco	1947
H. Gordon MacLean	Oakland	1947
Donald D. Lum	Alameda	1947

Committee on Associated Societies and Technical Groups

Edward F. Nippert	Los Angeles	1948
Peter Blong (Chairman)	Alhambra	1949
Robert A. Scarborough	San Francisco	1950

Committee on Health and Public Instructions

C. M. Burchfiel	San Jose	1948
George M. Uhl (Chairman)	Los Angeles	1949
Orrin Cook	Sacramento	1950

Committee on History and Obituaries

Robert A. Peers	Colfax	1948
E. T. Remmen	Glendale	1949
Morton Gibbons, Sr. (Chairman)	San Francisco	1950
George H. Kress (Honorary Historian)	ex officio	

Committee on Hospitals, Dispensaries and Clinics

Clarence E. Rees	San Diego	1948
Anthony J. J. Rourke	San Francisco	1949
Carroll B. Andrews (Chairman)	Sonoma	1950

Committee on Industrial Practice

Donald Cass (Chairman)	Los Angeles	1948
J. B. Josephson	San Jose	1949
Wayne Pollock	Sacramento	1950

Committee on Medical Defense

Edward G. Ewer	Oakland	1948
Louis J. Regan	Los Angeles	1949
Nelson Howard (Chairman)	San Francisco	1950

Committee on Medical Economics

H. Gordon MacLean (Chairman)	Oakland	1948
Howard W. Bosworth	Los Angeles	1949
Dell T. Lundquist	Palo Alto	1950

Committee on Medical Education and Medical Institutions

L. R. Chandler	San Francisco	1948
Francis Scott Smyth	San Francisco	1949
B. O. Raulston (Chairman)	Los Angeles	1950

Committee on Organization and Membership

Harold G. Trimble	Oakland	1948
Henry A. Randel	Fresno	1949
Carl L. Mulfinger (Chairman)	Los Angeles	1950

* Members appointed each year by the Chairman of the Council.

Committee on Postgraduate Activities

John C. Ruddock (Chairman)	Los Angeles	1948
Salvatore P. Lucia	San Francisco	1949
Edward Blair	Paso Robles	1950
L. Henry Garland	ex officio	

Committee on Publications

R. H. Sundberg	San Diego	1948
George W. Walker (Chairman)	Fresno	1949
George Dawson	Napa	1950

Committee on Public Policy and Legislation

Lloyd E. Kindall	Oakland	1948
E. T. Remmen	Glendale	1949
Dwight H. Murray (Chairman)	Napa	1950

Advisory Committee

Junius B. Harris	Sacramento
H. Randell Madeley	Vallejo
Wilson Stegeman	Santa Rosa

Committee on Scientific Work

L. Henry Garland (Chairman)	ex officio	
Howard F. West	Los Angeles	1948
Clayton Mote	San Francisco	1949
William O. Russell	Santa Barbara	1950
George B. Robson	(ex officio, Secretary, Section on Medicine)	
A. Morse Bowles	(ex officio, Secretary, Section on Surgery)	

Committee on Public Relations

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio.

George M. Uhl.....Chairman, Com. on Health and Public Instruction
Carroll B. Andrews..Chairman, Com. on Hospitals, Dispensaries, Clinics
Donald Cass.....Chairman, Committee on Industrial Practice
Nelson Howard.....Chairman, Committee on Medical Defense
Carl L. Mulfinger....Chairman, Committee on Organization, Membership
H. Gordon MacLean.....Chairman, Committee on Medical Economics
Dwight H. Murray....Chairman, Committee on Public Policy, Legislation
John C. Ruddock.....Chairman, Committee on Postgraduate Activities
John W. Cline.....President of California Medical Association
E. Vincent Askey.....President-Elect
L. Henry Garland.....Secretary-Treasurer

Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2009, 450 Sutter Street, San Francisco 8.

Cancer Commission

Henry J. Ullman	Santa Barbara	1948
David A. Wood (Sec'y, No. California)	San Francisco	1948
James F. Rinehart	San Francisco	1948
Lyell C. Kinney (Chairman)	San Diego	1949
L. Henry Garland	San Francisco	1949
Orville N. Meland, (Sec'y, So. California)	Los Angeles	1949
Homer Woolsey (Vice-Chairman)	Woodland	1950
Eric Larson	Los Angeles	1950
Harry E. Peters, Jr.	Oakland	1950

Physicians' Benevolence Committee

Axcel E. Anderson (Chairman)	Fresno
Elizabeth Mason Hohl	Los Angeles
Robert A. Peers	Colfax

OFFICERS OF SCIENTIFIC SECTIONS CALIFORNIA MEDICAL ASSOCIATION

Members who contemplate presentation of scientific papers should promptly address the secretary of the proper section, as per addresses which follow. Correspondence concerning scientific exhibits and medical and surgical films should be addressed to the Chairman of the Committee on Scientific Work: L. Henry Garland, M.D., 450 Sutter, San Francisco 8.

Anesthesiology

Chairman, Ida Heissig, 1691 Coolidge Avenue, Altadena.
Secretary, William B. Neff, 2400 Vallejo Street, San Francisco.

Dermatology and Syphilology

Chairman, Maximilan E. Obermayer, 2007 Wilshire Boulevard, Los Angeles 5.
Vice-Chairman, Robert A. Stewart, 2490 Channing Way, Berkeley.
Secretary, W. W. Duemling, 3367 Fourth Avenue, San Diego.
Assistant Secretary, Ervin H. Epstein 1904 Franklin Street, Oakland.

Eye, Ear, Nose and Throat

Chairman, Dohrmann K. Pischel, 490 Post Street, San Francisco 2.
Vice-Chairman, Russell Fletcher, 2298 Durant Avenue, Berkeley.
Secretary, George L. Kilgore, 1062 Myrtle Way, San Diego 3.

General Medicine

Chairman, Howard O. Dennis, 9370 Wilshire Boulevard, Beverly Hills.
Secretary, George B. Robson, 490 Post Street, San Francisco 2.
Assistant Secretary, Lewis T. Bullock, 3875 Wilshire Boulevard, Los Angeles.

General Practice

Chairman, Stanley R. Truman, 1904 Franklin Street, Oakland 12.
Secretary, Karl L. Dieterle, 736 South Flower Street, Los Angeles.

General Surgery

Chairman, Clarence J. Berne, 1136 West 6th Street, Los Angeles.
Secretary, A. Morse Bowles, 541 Fourth Street, Santa Rosa.
Assistant Secretary, Conrad J. Baumgartner, 409 North Camden Drive, Beverly Hills.

Industrial Medicine and Surgery

Chairman, Keene O. Haldeman, 350 Post Street, San Francisco 8.
Vice-Chairman, Joseph D. Peluso, 315 West Ninth Street, Los Angeles 15.
Secretary, Nelson J. Howard, 490 Post Street, San Francisco 2.

Neuropsychiatry

Chairman, Robert B. Aird, University of California Hospital, San Francisco 22.
Secretary, Cullen W. Irish, 1930 Wilshire Boulevard, Los Angeles 5.

Obstetrics and Gynecology

Chairman, T. Floyd Bell, 431 Thirtieth Street, Oakland 9.
Vice-Chairman, A. M. McCausland, 3780 Wilshire Boulevard, Los Angeles 5.
Secretary, D. A. Dallas, 490 Post Street, San Francisco 2.

Pathology and Bacteriology

Chairman, A. F. Brown, 318 North Central Avenue, Glendale 3.
Secretary, Gerson R. Biskind, 240 Stockton Street, San Francisco 8.
Assistant Secretary, C. S. Small, Loma Linda.

Pediatrics

Chairman, C. I. Mead, 1930 Truxton Avenue, Bakersfield.
Secretary, Alice Potter, 1418 Ninth Avenue, San Francisco 22.
Assistant Secretary, Carl A. Erickson, 65 N. Madison Avenue, Pasadena 1.

Public Health

Chairman, Harold D. Chope, P. O. Box 111, Stockton.
Vice-Chairman, Malcolm H. Merrill, 3093 Life Science Building, U. C., Berkeley.
Secretary, Edward Lee Russell, P. O. Box 355, Santa Ana.

Radiology

Chairman, Douglass R. MacColl, 2007 Wilshire Boulevard, Los Angeles 5.
Secretary, Sydney F. Thomas, Palo Alto Clinic, Palo Alto.

Urology

Chairman, Lionel Paget Player, 384 Post Street, San Francisco.
Vice-Chairman, Nathan G. Hale, 1122 26th Street, Sacramento.
Secretary, Frederick A. Bennetts, 1921 Wilshire Boulevard, Los Angeles.

C.M.A. Committee on Scientific Work: For membership of State Association Committee, see roster on page 2, or address: L. Henry Garland, M.D., Chairman, 450 Sutter, San Francisco 8, Calif.

California Medical Association Delegates and Alternates to the American Medical Association

DELEGATES		ALTERNATES
Robertson Ward, San Francisco	(1946-1947)	Anthony B. Diepenbrock, San Francisco
Sam J. McClendon, San Diego	(1946-1947)	Bon O. Adams, Riverside
Lowell S. Goin, Los Angeles	(1946-1947)	Louis J. Regan, Los Angeles
John W. Green, Vallejo	(1946-1947)	H. Randall Madeley, Vallejo
H. Gordon MacLean, Oakland	(1947-1948)	Leopold H. Fraser, Richmond
E. Vincent Askey, Los Angeles	(1947-1948)	William Benbow Thompson, Los Angeles
John W. Cline, San Francisco	(1947-1948)	C. Kelly Canelo, San Jose
Donald Cass, Los Angeles	(1947-1948)	
Ralph B. Eusden, Long Beach	(1947-1948)	Elizabeth Mason Hohl, Los Angeles

Woman's Auxiliary to the California Medical Association

State Auxiliary Officers

President, Mrs. Norman D. Morgan, 2290 Vallejo Street, San Francisco 23.
President-Elect, Mrs. Lawrence Gundrum, 1359 Oak Grove Avenue, San Marino.
First Vice-President, Mrs. Raymond T. Wayland, 696 E. San Carlos Street, San Jose.
Second Vice-President, Mrs. Roger McKenzie, 138 Twenty-fifth Avenue, San Francisco.
Recording Secretary, Mrs. H. M. Currey, 2006 Victoria Drive, Santa Ana.
Treasurer, Mrs. Stanley Truman, 1054 Ashmore Avenue, Oakland.
Corresponding Secretary, Mrs. J. Clifford Long, 2027 Broadway, San Francisco 15.

County Presidents

Alameda County—Mrs. Hobart Rogers, 1137 Mandana Boulevard, Oakland 10.
Butte-Glenn County—Mrs. E. L. Meyers, 490 E. Second Avenue, Chico.
Contra Costa County—Mrs. R. J. P. Harmon, 7249 View Avenue, Richmond.
Fresno County—Mrs. G. W. Walker, 630 Peralta Way, Fresno.
Humboldt County—Mrs. Daryl Broderick, 1725 L Street, Eureka.
Kern County—Mrs. Robert J. Dowds, 2007 Second Street, Bakersfield.
Los Angeles County—Mrs. Hubert T. Wilken, 230 Twenty-first Street, Santa Monica.
Marin County—Mrs. Ernest Lion, Winding Way, Ross.
Merced County—Mrs. Mary Helene Fountain, 824 Twentieth Street, Merced.
Monterey-San Benito County—Mrs. G. Eberhardt, Box 66, Gonzales.
Orange County—Mrs. Charles F. W. Kohlenberger, 310 N. Pomona Avenue, Fullerton.
Riverside County—Mrs. Franklin B. Mead, 3595 Oakwood Place, Riverside.
Sacramento County—Mrs. Dudley V. Saeltzer, Jr., 1124 Forty-seventh Street, Sacramento 16.
San Diego County—Mrs. Charles W. Rees, 4496 Trias Street, San Diego 3.
San Francisco County—Mrs. Robertson Ward, 3515 Pacific Ave., San Francisco 18.
San Joaquin County—Mrs. Frank A. McGuire, 730 N. Lincoln Street, Stockton.
San Luis Obispo County—Mrs. R. O. Pearman, 850 Buchon Street, San Luis Obispo.
San Mateo County—Mrs. Robert O. Sherwood, 700 Costa Rica Avenue, San Mateo.
Santa Barbara County—Mrs. William M. Moffat, Hope Ranch Park, Santa Barbara.
Santa Clara County—Mrs. Raymond T. Wayland, 696 E. San Carlos Street, San Jose.
Santa Cruz County—Mrs. F. C. Morgan, 93 Walnut Avenue, Santa Cruz.
Solano County—Mrs. C. T. Alexander, 1607 Illinois Street, Vallejo.
Sonoma County—Mrs. Herbert Every, East Haven Drive, Santa Rosa.
Stanislaus County—Mrs. J. L. Azevedo, 830 Magnolia Street, Modesto.
Tulare County—Mrs. Frank Wiens, 70 E. Putnam Street, Porterville.
Ventura County—Mrs. W. C. Huff, 161 Birch Street, Oxnard.

Miscellaneous California Medical Associations

Board of Medical Examiners of the State of California

San Francisco—515 Van Ness Avenue, Room 214. (2)
Los Angeles—906 State Building.
Sacramento—Business and Professional Building, 1020 N Street, Room 536.
Secretary, Frederick N. Scatena, M.D., 1020 N Street, Room 536, Sacramento 14.

Medical Society of State of California

Optional Medical Defense—C.M.A. Members. 131 South Rampart Blvd., Los Angeles 4, c/o G. H. Kress, M.D.

Department of Public Health of the State of California

San Francisco—1122 Phelan Building, 760 Market Street, San Francisco 2; UNderhill 8700.
Sacramento—631 J Street.
Los Angeles—State Office Building, 217 West First Street, MAdison 1281.
Director, Wilton L. Halverson, 603 Phelan Building, 760 Market Street, San Francisco 2.

The Public Health League of California

Executive Secretary, Ben H. Read, San Francisco office, 251 Kearny Street 8, phone SUtter 8470, Los Angeles office, 108 West Sixth Street 14, TUcker 9069.

Medical Schools in California

University of California Medical School, Medical Center, San Francisco 22.
Stanford University School of Medicine, 2398 Sacramento St., San Francisco 15.
School of Medicine, University of Southern California, 3551 University Ave., Los Angeles 7.
School of Medicine, College of Medical Evangelists, 312 N. Boyle Ave., Los Angeles 33.

(For roster of County Society officers, see last month's issue.)

HIVES SUFFERERS GAIN RELIEF FROM ITCHING WITH BENADRYL

Benadryl, a drug which inhibits the action of histamine, a poison released by the tissues in allergic reactions, is highly effective in the treatment of certain diseases of the skin such as hives, according to two Rochester, Minn., physicians.

Writing in the July 19 issue of *The Journal of the American Medical Association*, the physicians—Paul A. O'Leary and Eugene M. Faber from the section on dermatology and syphilology, Mayo Clinic—prescribed Benadryl to be taken by mouth every three to four hours for 35 patients who had acute hives. Twenty of the patients were completely relieved in from one to two days; the condition of 12 was improved and three patients were not benefited.

The authors state that when Benadryl is administered, relief from the intense itching usually occurs in 20 to 60 minutes, with reduction of the swelling in from two to six hours. However, relief is obtained only while the drug is being used.

Another group of 75 patients with chronic hives, which may last for many years, were treated with the drug with the following results: 48 were entirely relieved while they were taking Benadryl, 17 were partially relieved and 10 obtained no benefit.

There have been a great number and variety of treatments tried but no single one has been of consistent benefit to patients who have hives chronically. The physicians therefore feel that Benadryl has given striking relief to most of these patients who may be wholly or partially incapacitated because of intense itching, insomnia and disfigurement.

Another 76 patients with miscellaneous skin diseases were

(Continued on Page 16)

HIVES SUFFERERS GAIN RELIEF FROM ITCHING WITH BENADRYL

(Continued from Page 12)

treated with Benadryl but few experienced the relief of the hives sufferers.

"Side reactions occurred among 31 per cent of the patients in this study," according to the physicians, "but were severe enough to warrant discontinuance of the administration of Benadryl to only 10 patients."

The side reactions in order of frequency were drowsiness, dizziness, weakness and dryness of the mouth. Some patients complained of being "jittery," "on edge," "nervous," "confused," "poorly coordinated," "nauseated" and "excited."

"Side reactions usually occur during the first few days after the administration of the drug is begun and frequently diminish in severity or disappear entirely after several weeks of treatment," state the authors.

NEW TIME SET FOR DR. GRAHAM PROGRAM

A new time of presentation has been announced by the Bureau of Health Education for the American Medical Association-Mutual Broadcasting System weekly radio dramatization, "Stephen Graham, Family Doctor." This program, just extended to November 17, will be aired each Sunday afternoon at 2 o'clock, Eastern Standard Time.

The program portrays the family doctor as he lives and practices in a fictitious but typical average middle size American city set in the midst of an imaginary rural area.

POLIOMYELITIS CAN BE DIAGNOSED WITHIN 24 HOURS OF ONSET

Diagnosis of infantile paralysis can usually be made within 24 hours of the onset of the disease, according to John F. Pohl, M.D., of Minneapolis, and treatment should begin immediately in order to relieve the discomfort of patients and to minimize crippling.

Writing in the July 26 issue of *The Journal of the American Medical Association*, Dr. Pohl, who is from the Elizabeth Kenny Institute, states that "an analysis of 1,125 cases of poliomyelitis treated in Minneapolis during the 1946 epidemic reveals that the symptoms and observations are sufficiently characteristic to enable the diagnosis to be established in most patients within 24 hours of the onset. The study also discloses that paralsyis is not a useful diagnostic sign because paralysis or weakness of the muscles is not a common early event and in a considerable number of cases does not occur at all. To await the appearance of paralysis to confirm the diagnosis or to begin treatment is inadvisable."

Of the 1,125 cases, 736 or 65.4 per cent progressed to paralysis of some degree within 15 days of onset but 389 or 34.6 per cent did not show paralysis at any time. Sixty-eight patients or six per cent died.

Symptoms of the first 24 hours are: headache, fever, nausea, vomiting, loss of appetite, stiff neck, stiff back, painful arms and legs and general malaise with listlessness.

Listen in every Sunday
1:30 p.m.
"CALIFORNIA CARAVAN"
American Network

INCREASE SCOPE OF OPERATIONS WITH FEWER SURGICAL DANGERS

The dangers of surgery have diminished as the variety and magnitude of operations have increased, according to Robert H. Kennedy, M.D., of New York, writing in *Hygeia,* health magazine of the American Medical Association.

Dr. Kennedy, who is surgical director of the Beekman-Downtown Hospital and attending surgeon in charge of the tumor division of the New York Post-Graduate Hospital, states that "in an emergency operation a person is no longer put on the operating table until after fluid has been given him if he is dry, nourishment if he is starved, blood if he is anemic, germ-fighting medicines called antibiotics, such as penicillin, if he is infected. All of these can be injected into veins if the stomach does not tolerate food. Before the surgeon will operate careful survey must show that the patient is in the best possible condition considering the emergency."

Great strides have been made in the field of anesthesia. There are now a large number of methods of anesthesia and drugs for the specially trained anesthetist to choose from, each having a place according to special indications—local and spinal anesthesia with which the patient need not be put to sleep; intravenous anesthesia, which does not require breathing anything into the lungs, inhalation anesthesia with a finely geared machine which delivers exact proportions of several different gases. Most of these are accompanied by breathing in oxygen to maintain body functions and keep all tissues in good condition.

The author points out that "modern surgery is only about 60 years old. This period represents almost all the advances in surgical knowledge. With each decade it is thought that all surgical discoveries have been made but new ideas always

(Continued on Page 22)

INCREASE SCOPE OF OPERATIONS WITH FEWER SURGICAL DANGERS

(Continued from Page 20)

come forth opening up new fields for doing good. . . . During almost every year it is found that some condition is amenable to an operation previously unknown. Many persons formerly condemned to death, or to a life of permanent disability or discomfort, can now be returned to normal life. There is practically no area left in the body which cannot be approached surgically with safety."

For example, tracts in the brain can be cut to improve greatly the condition of some persons previously confined in insane asylums. Defects in the skull resulting from accidents can be filled in completely and permanently with a metal or plastic that the tissues tolerate well. A new drug, thiouracil, has made operations for goiter much safer and resulted in less reaction.

Today a lobe or a whole lung can be removed. Abnormalities of the major blood vessels within the chest can be sidetracked. An operation which requires cutting the nerve supply to the stomach is effective for stomach ulcers. Disease of the liver resulting in shutting off of its necessary circulation is being relieved by shunting the circulation to other vessels through metal tubes. A damaged pancreas, an organ lying behind the stomach, can be removed in whole or in part since laboratory experiments have found substitute products for the secretions of the organ.

These and many other operations have been aided by such modern technics as examination by x-rays, visualization through tubes inserted into various organs—for example, the bronchoscope for removing foreign bodies from the lungs—blood tests, which are constantly increasing in variety and value, and removal of a portion of a tumor for pathological diagnosis.

POINT OUT AIDS FOR DIAGNOSING ANEMIAS IN INFANTS, CHILDREN

The anemias of infancy and childhood do not differ greatly from those of the adult but diagnosis is often difficult because of the normal blood changes which take place from birth through childhood, according to four doctors presenting individual reports in the July 19 issue of *The Journal of the American Medical Association.*

Carl H. Smith, M.D., from the New York Hospital and the Department of Pediatrics, Cornell University Medical College, New York, points to certain pertinent information which will aid diagnosis, such as the onset of pallor, the appearance of black and blue spots, the loss of blood from the bowel, infection, including exposure to animal parasites, the use of drugs such as the sulfonamides known to affect blood formation, kidney disease, the rapidity of growth, overfeeding of milk with the refusal of solid foods, and the existence of anemia in the mother during pregnancy.

Information in regard to race and nationality is important in the diagnosis of sickle cell anemia, a peculiar red cell deformity, and Mediterranean anemia, says Dr. Smith. Although sickle cell anemia is predominantly a disease of Negroes, it has been observed occasionally in the white families which are principally of Mediterranean origin.

"In Mediterranean anemia," writes the physician, "the patients are mainly of Greek, of Italian (principally Sicilian and from the Italian peninsula below Naples) or, less frequently, of Syrian origin. . . . On the basis of previous studies and of an investigation now in progress the evidence is conclusive that in every family with a child severely affected with Mediterranean anemia and requiring periodic trans-

(Continued on Page 28)

POINT OUT AIDS FOR DIAGNOSING ANEMIAS IN INFANTS, CHILDREN

(Continued from Page 26)

fusions of blood both parents revealed evidences of the disease."

Anemia is a condition in which the blood is deficient in either quantity or quality. Wolf W. Zuelzer, M.D., from the Anemia Clinic, Children's Hospital of Michigan and Departments of Pediatrics and Pathology, Wayne University College of Medicine, Detroit, points to prematurity as a cause of anemia.

Premature infants usually fail to receive the deposits of iron, building blocks of the blood cell, normally transferred during the latter part of pregnancy and therefore have an inadequate reserve to draw upon for normal growth.

The full term infant usually has an adequate reserve of iron to last until it can be replenished by iron from the diet. Dr. Zuelzer says that "if food rich in iron is not then made available, anemia will develop on a nutritional basis alone. However, a deficiency anemia due to lack of iron is not necessarily the result of inadequate dietary intake; in fact, purely nutritional anemia is relatively infrequent even in infancy. In most instances infection is a precipitating factor."

Analysis of 1,500 consecutive admissions to the Boston Floating Hospital was made by James Marvin Baty, M.D., to determine the incidence of anemia in hospital practice. Dr. Baty is from the Department of Pediatrics of the Tufts College Medical School, the Boston Floating Hospital and the Children's Clinic of the Boston Dispensary.

"It should be pointed out that the Boston Floating Hospital is largely charitable," he states, "and that most of the patients are unable to pay the costs of medical care. The hygienic and dietary background of such a group of children

(Continued on Page 30)

POINT OUT AIDS FOR DIAGNOSING ANEMIAS IN INFANTS, CHILDREN

(Continued from Page 28)

is not comparable to that of patients under the care of private physicians. Furthermore, only those patients with severe anemia and those with unusual conditions received the careful consideration of the hematologist [blood specialist]."

Of these 1,500 patients, 514 or 34 per cent, showed a definite anemia. A breakdown by age groups indicates that the second year of life is the period in which there is the greatest incidence of anemia, about 51 per cent. Approximately 45 per cent of the children under two years of age and 25 per cent of those between ages two and 12 were anemic.

In 92 per cent of the 514 patients the anemia was the result of infection, dietary deficiency, prematurity or some combination of these three factors.

H. G. Poncher, M.D., Professor of Pediatrics at the University of Illinois School of Medicine, Chicago, states that anemia in infancy is predominantly due to iron deficiency but other necessary materials may also be lacking.

"Such evidence, however," states the author, "does not justify the numerous shotgun proprietary [commercially protected drugs] preparations that are constantly offered to the [medical] profession without clinical facts to support their use. Preparations of this type increase the cost of medical care and minimize the careful evaluation of the cause of the anemia which is so important to well conceived and intelligent treatment."

Anemia occurring during the age period two to six years is usually due to nutritional deficiency and infection, which interferes with the elements necessary for blood building. Iron and liver treatment produce the best results in these patients after the cause of the infection has been removed.

Anemia during the school age period is predominantly due to chronic infection, chronic inflammatory disease or loss of blood. Streptococcic infections and their complications head the list. Other prominent causes are chronic sinusitis, pneumonia, an inflamed kidney, rheumatic fever and tuberculosis.

Treatment should consist of removing the cause of the anemia, together with the institution of a balanced diet or if the anemia is severe, blood transfusions should be given until the cause is removed.

411 First Avenue

California MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 67 OCTOBER, 1947 NO. 4

Indications for Surgery of the Ovary*

LUDWIG A. EMGE,† M.D., *San Francisco*

SINCE its inception early in the 19th Century the surgery of the ovary, like all other surgical procedures, has undergone many changes, some good and some bad. As a whole, it has improved in line with progress made in the knowledge of physiology. Some of the misconceptions of a less enlightened period are still with us and need a thorough overhauling. This is particularly true of the indications for oophorectomy which altogether too frequently are based on a faulty interpretation of the importance of organic findings.

The original and sole indication for surgery of the ovary was the presence of a large tumor and the original and sole operation for the correction of that condition was ovariotomy. The operation originally introduced by Ephraim McDowell, in 1809, was modified by such great ovariotomists as Nathan Smith, Spencer Wells and Atlee, but the indication remained unchanged for nearly sixty years. Atlee[2] later extended the principle of the operation to the removal of large uterine fibroids. The early ovariotomists closely followed the precepts laid down by McDowell[15] in his review of a series of ovariotomies performed by him between 1809 and 1816. McDowell was deeply conscious of his responsibility in undertaking what was then a very hazardous operation, and when reviewing his work in 1819 he counseled that the operation should be undertaken only by well qualified surgeons. The closing remark of his review is a classical example of modesty and surgical conscience, and well worth repeating here. He said: "I think my description of the mode of operating and of the anatomy of the parts concerned is clear enough to enable any good anatomist, possessing judgment requisite for a surgeon, to operate with safety. I hope no operator of any other description may ever attempt it. It is my ardent wish that this operation may remain to the mechanical surgeon forever incomprehensible."

Empiricism in medicine and surgery was at its height in the last quarter of the 19th Century. No wonder then that speculation was rife to connect the ovaries with poorly understood functional disturbances. In 1872 Battey,[5] of Atlanta, Georgia, pleaded for the liberalization of ovariotomy to include dysmenorrhea and various neuroses. The immediate response was one of caution and restraint, but since the physiology of ovulation and menstruation was not well understood other speculative surgeons took up Battey's plea. The result was the wholesale removal of ovaries on any pretext. The development of anesthesia, antisepsis and asepsis lessened many of the hazards of surgery and no doubt fostered the liberalization of oophorectomy to the point of absurdity. The return to a saner attitude in ovarian surgery came with a better understanding of ovulation and menstruation, though according to recent reports the nuisance by no means has been eliminated. For instance, in a recent discussion of the physiological approach to the problem of oophorectomy, Mengert[16] pointed out that in a certain well-conducted hospital 75 per cent of 1,320 ovaries removed during a period of four years were found to be structurally normal, while only 25 per cent revealed disease. This serious indictment parallels Miller's recent report on hysterectomy,[17] subtitled, "Therapeutic Necessity or Surgical Racket?" Miller's report likewise indicates that sound indications for hysterectomy frequently are disregarded. Personally, I believe that the abuse of either of these operations is not so much willful infraction of surgical ethics as a lack of proper understanding of the physiology of these organs. If the

* Read before the Section on General Practice at the 76th Annual Session of the California Medical Association, Los Angeles, April 30-May 3, 1947.

† Clinical Professor of Obstetrics and Gynecology, Stanford University School of Medicine.

California MEDICINE

OWNED AND PUBLISHED BY THE CALIFORNIA MEDICAL ASSOCIATION
450 SUTTER, SAN FRANCISCO 8 PHONE DOUGLAS 0062

For Information on Preparation of Manuscript, See Advertising Page 2

EDITORIALS

Medical Care in Hospitals

Despite the fact that a sprained ankle or an attack of acute rhinitis may be better and more economically taken care of at home, the tendency is increasing for our fellow citizens to go to a hospital for such minor ailments. Their visit involves not only the expense of registration, bed and nursing care, but basic diagnostic medical procedures, which, if necessary, could often be performed with equal efficiency at a physician's office near the home. A hospital is the logical place to refer patients for procedures of a major or complicated nature, requiring elaborate medical or surgical care; the oxygen tent, the operating room, the incubator all function more efficiently in a well run hospital. The doctor's office or patient's home is the logical place wherein about 85 per cent of illness can be taken care of, and where the added expense of institutional overhead can be avoided. Most diagnostic and many therapeutic procedures and some operations can be performed in a well equipped physicians' office or physicians' medical building.

In recent years the increased cost of operating institutions has forced hospital administrators and boards of trustees to seek sources of income over and above those which might be described as legitimate. The primary function of the average private hospital is to furnish bed, board and nursing care to sick persons. With the true cost of furnishing a bed climbing daily higher, many hospitals have sought "hidden taxes" in the form of professional revenue from various medical services. Many have gone so far as to choose departmental physicians on the basis of the income they will accept rather than the basis of their professional qualifications. Result: the patient expecting and paying for a highly competent type of diagnostic medical service often receives an inferior one.

The patient is in the hospital to be cured of some ailment, sometimes a serious one such as cancer or pneumonia. He is anxious and willing to secure the best type of medical attention available. If it is a question of removal of a breast or amputation of a leg, upon whose opinion must this grave decision sometimes be made? Upon the pathologist's or the radiologist's. With the highest type of specialist in these fields, the patient is apt to obtain accurate diagnosis and greater opportunity for cure. Similarly, other members of the medical staff benefit by the advice of their association and consultation with experts. With inferior staff members, the reverse is true.

It probably never occurs to the average patient that his tumor may be submitted to x-ray examination or pathological study by a specialist chosen not because he is the best available man in his field, but because he will accept a salary. His life will be in the hands of a man often inferior to a colleague working on the outside because the hospital would not permit the latter to practice his profession on an ethical and legal basis. There *are* instances, fortunately, in which the attending physician has been sufficiently alert to this danger to insist that the patient be taken out of the hospital by ambulance for necessary special diagnostic or therapeutic procedures, and then returned to the hospital.

In *Hospital Management* for May, 1947, there appears a frank statement of the problem, a statement

CALIFORNIA MEDICAL ASSOCIATION

NOTICES AND REPORTS

Reports of C.P.S. Officers to Administrative Members

Following are the reports made to the administrative members of California Physicians' Service, meeting in Los Angeles, April 30, 1947, by Dr. Lowell S. Goin, president of the Board of Trustees of C.P.S., Dr. Chester L. Cooley, secretary, and Mr. W. M. Bowman, executive director.

DR. GOIN: I am delegated by the By-Laws of the California Physicians' Service as your President to address you. I shall not trouble you with very many remarks. Immediately thereafter you will hear from the Secretary of the Service and from its Executive Director who reports on the progress of the California Physicians' Service during the past year and I am sure you will be very much impressed with the progress that has been made. This progress is due in no small measure to the efforts of the administration but primarily it is due to the increasing interest and cooperation of the doctors of California. My few remarks are directed towards increasing and continuing that interest and that support from the doctors of California in behalf of the California Physicians' Service. I yield to no one in any way that we do not continue the practice of medicine as we have known it in the past and that we could remain the family physician and friend and the advisor of the sick man and his family; that we could continue to administer medical care on the fee-for-service method as it has been given for so many years. Unfortunately, the social order changes. Whether for the better or the worse remains to be seen but certainly it changes.

The magazine *Fortune*, about two years ago last December, had an article on the problem of medical care. I think you would all agree that *Fortune* is by no means a left wing sheet. It is a big, expensive magazine and it is devoted to big business. If you haven't read the article, I commend it to you.

In the article the writer makes this statement.

"Medical care has become a problem in America because the conscience of America has made it one." I don't believe that anyone could contemplate the earnest attempts that have been made in the past fifteen years to enact health insurance legislation or read the vast amount of literature that has appeared on the subject and remain convinced that there is no problem of medical care. For myself I am prepared to concede that there is a problem. I agree that the distribution of doctors is not ideal, and that there are areas in the country where good medical care is difficult to obtain; that the cost of medical cares are totally unpredictable and that frequently it falls with a catastrophic effect upon individuals and families very ill-prepared to receive them.

Now, social reform to the contrary, the fact is that the nation's health is in an admirable state. We are the healthiest people in the world. Our morbidity and mortality rate is declining steadily. Our longevity and life expectancy increases constantly. To achieve these miracles the doctors of America have given freely of themselves without regard to the ability of the patient to pay. Those who would have America believe that ability to pay is the criteria for health and that the poor man who is ill would receive no medical care are either totally ignorant or for reasons of their own are uttering malicious nonsense. Nevertheless, I greatly fear that we are approaching the end of the era in which we have administered medical care on a fee-for-service basis. This is not because we have failed with our task. It is because the scope of our science is becoming so vast and because our knowledge of it is becoming so complex that if we are to apply for the benefit of the sick the knowledge that we now possess, the costs of medical care must necessarily rise, frequently to the point

SOCIALIZED MEDICINE A THREAT TO QUALITY OF MEDICAL SERVICE

Dr. Ernest E. Irons, Chicago, a member of the Board of Trustees of the American Medical Association, says that "governmental regimentation of medicine would give the American people an inferior rather than a better quality of medical service."

Writing on "Medicine and Economics" in the July 19 issue of *The Journal of the American Medical Association*, Dr. Irons states that such regimentation "would be another long step toward the destruction of free enterprise and of American democracy."

Dr. Irons, who is past president of the American College of Physicians, a war-time member of the committee on drugs and medical supplies of the National Research Council and past chairman of the American Board of Internal Medicine, points out how socialized medicine would affect the quality of medical service for the American people. Dr. Irons says in part:

That socialized medicine interferes with the physician-patient relationship is self evident by the recognition of advocates of socialized medicine of the necessity of providing a panel. The most shrewd advocates of socialized medicine have failed utterly in their contention that their plan will not interfere in this fundamental confidential relation of doctor to patient. It always has and always will. Indeed, this interference is part of their plan, although the more ardent advocates will not admit it . . .

Physicians have up to now been individualists; they do their best work on a competitive basis. If the physician is alert, well trained, honest, proud of his profession and its achievements, he will strive continually to improve and give better service, and he is rewarded by the gratitude of his patients and in increase in his clientele and emoluments. To the degree that he is poorly prepared, slothful and loses his incentive to improve, he will do less creditable work. He will be limited by the deadly average of attainment, loss of initiative and dependence on a paternal government, which has always been the next step downward in socialistic governments of history. The removal of the individual incentive is fatal to progress, and human nature is the same, irrespective of occupation. Socialized medicine will reduce the quality of public service as it has in modern governments elsewhere.

Many social injustices and inequalities remain to be corrected. These become more evident as our general standard of living rises from decade to decade, but the remedying of these faults should not be made the occasion for destruction of past gains. In medicine, inadequacies in medical care are closely interlocked with general economic deficiencies. Understaffed and economically poor communities and areas require individualization of treatment, and a plan which will be efficient in one region may not work in another with a different local ideology and economy . . .

We have already seen in our own national life the ill effects of great business monopolies: the Sherman Antitrust Act was passed to prevent the stifling of competition. Monopoly of labor through unions originally designed to obtain justice and fair treatment for labor has now resulted in profit to a few of one class, to the detriment of a still larger class of labor, by denying them free opportunity to work. Monopolies whether of capital or of labor work to the benefit of their sponsors only so long as they are exceptional—when they become general they are destructive of the general welfare and ultimately destroy their creators. For this reason socialists and communists favor monopolies in business and in medicine as factors forwarding their own objectives . . .

Care of people by a paternalistic government results in loss of their sense of personal responsibility, first to participate in government, and later to make any effort to contribute to the general welfare.

In urging the theory of the right of a citizen to be cared

(Continued on Page 38)

SOCIALIZED MEDICINE A THREAT TO QUALITY OF MEDICAL SERVICE

(Continued from Page 34)

for, social workers, betrayed by their own idealism, forget that this citizen has also an obligation in a democracy himself to contribute to the general welfare. Without insistence on this obligation, democracy fails.

We are just now emerging from a period of governmental regulation and centralization under bureaucracies made necessary by total war. This period, in which we have become somewhat inured to regimentation, is especially dangerous to our democracy. Socialist and totalitarian governments grow by steps, slowly at first, but with a steadily increasing tempo and always by deluding the people into the belief that the new will be better than what they already have. Government monopoly whether in business or in medicine inevitably leads to the abuse of power and deterioration of quality of service.

TYPHOID DEATH RATE DECLINING STEADILY IN LARGE U. S. CITIES

Typhoid fever deaths in 93 large U. S. cities have shown a steady decline from 95 in 1942 to 62 in 1946, according to the 33rd annual report appearing in the July 26 issue of *The Journal of the American Medical Association.*

In the 78 cities for which data have been available since 1910, the report says, there occurred 54 deaths from typhoid in 1946, 80 in 1945, 66 in 1944 and 78 in 1943. This provides a new low with a rate of 0.15 per hundred thousand of population. The previous low was 0.18 in 1944.

Figures for the report were obtained from local health officers, who were asked to record an estimate of population.

The number of cities with no typhoid death during the past two or more years has increased from 25 in 1941 and 41 in 1945 to a new high of 49 in 1946. Fort Wayne continues to head the list with no death in 12 years. Fall River and

(Continued on Page 42)

TYPHOID DEATH RATE DECLINING STEADILY IN LARGE U. S. CITIES

(Continued from Page 38)

Lynn report no death in 10 years, Cambridge no death in nine years. Hartford, Springfield and Yonkers have clear records for eight years. South Bend reports no typhoid death among residents for 11 years.

The number of cities with no death from typhoid has increased from 56 in 1945 to 60 in 1946. Charlotte and Gary, not included in the group of 93 cities, also report no death. This is by far the best showing, and there remains no city with a rate of 2.0 or more. The number of cities with rates of less than 1.0 has increased by one (88 in 1946). Forty-seven cities (49 with Charlotte and Gary) record no typhoid death in 1945 and 1946.

The New England cities with a population of 2,579,152 have set a new all-time record with no death from typhoid in 1946. The East North Central cities, although reporting a new low rate (0.06), are now in second place. They were in first place in 1945 (0.07). The West North Central cities follow close behind (0.07) and nose out the Middle Atlantic cities (0.11). Only the Mountain and Pacific cities record a higher death rate for 1946 (0.31) than for 1945 (0.17).

Twelve of the large Middle Atlantic cities (there were 13 in 1945), with a population of 13,129,185, report no death from typhoid in 1946. These cities have a group rate (0.11) which is but slightly higher than that of the East North Central and West North Central cities. It is much lower than the rate for 1945 (0.23) but not as low as that for 1943 (0.08). In 1946 there were 14 deaths, 13 among resi-

(Continued on Page 46)

TYPHOID DEATH RATE DECLINING STEADILY IN LARGE U. S. CITIES

(Continued from Page 42)

dents; in 1945 there were 30, 25 among residents; in 1943 there were 11, nine among residents. New York records eight deaths in 1946, all among residents (there were 11 in 1945, 13 in 1944). The low mark was reached in New York in 1943 with four deaths, three among residents. New York reports a localized outbreak with 20 cases and no deaths in August 1946; the outbreak was attributed to fresh vegetables contaminated by sewage backed up out of a toilet bowl in an apartment immediately over the vegetable store.

The rate (0.44) for the South Atlantic cities (population 2,727,985) is twice the low rate for 1944 (0.22) but is significantly lower than the rate for 1945 (0.62). In these cities there occurred 12 deaths in 1946, 17 in 1945, six in 1944.

The East North Central cities (population 9,386,378) have lost first place, which rank they held in 1945 and back in 1941 and 1938. Fourteen (13 exclusive of Gary) of the cities in this group report no death from typhoid in 1946. The number of typhoid deaths decreased from seven in 1945 (33 in 1940, 13 in 1944) to six in 1946, a new low.

The six cities in the East South Central group (population 1,286,747) show a decrease in the death rate (0.54 in 1946, 0.70 in 1945). However, a lower death rate (0.31) was recorded in 1944 and the same rate in 1942 (0.54). This group has the highest group rate for 1946, a position which it also held in 1945, the South Atlantic cities being next (0.44).

The West North Central cities (population 2,716,484) show a decrease in the number of deaths from three to two. The death rate declined from 0.11 in 1945 (it was the same in 1943 and 1944) to 0.07 in 1946.

(Continued on Page 48)

TYPHOID DEATH RATE DECLINING STEADILY IN LARGE U. S. CITIES

(Continued from Page 46)

The eight cities of the West South Central group (population 2,048,692) report a continued reduction in the death rate (2.00 in 1940, 0.83 in 1943, 0.59 in 1945, 0.39 in 1946). The actual number of deaths decreased from 12 in 1945 (41 in 1940) to eight in 1946, the lowest on record. Noteworthy is the reduction in the death rate of the cities of this group from 5.36 for the five-year period, 1931 to 1935, to a new low of 0.39 in 1946.

The 11 cities (excluding Sacramento) in the Mountain and Pacific states (population 4,186,039) report an increase from seven in 1945 to 13 in 1946 (there were but five deaths in 1944). The rate has increased from 0.17 to 0.31. (It was 0.12 in 1944.) This is the only group of cities which records more deaths from typhoid in 1946 than in 1945.

In conclusion, the report states that "for 1946 the health officers report only a few localized outbreaks of typhoid. Improvement has been general throughout the country, and typhoid as a cause of death in these cities is fast approaching the vanishing point. The war years do not appear to have contributed materially to the typhoid problem in the large cities."

"MODERATE DRINKING" IMPLIES TAKING TWO COCKTAILS A DAY

A moderate drinker takes two cocktails or highballs a day, states a medical consultant in answer to a query in the July 12 issue of *The Journal of the American Medical Association.*

His reply says that "for the average, so-called healthy adult, on a good diet, two cocktails or highballs a day would, by most informed people, be considered 'taking alcohol in moderation,' particularly if not taken on an empty stomach before the morning breakfast, and if taken shortly before, during or shortly after the evening meal. But taken under identical conditions and rate, this quantity of alcohol would produce much higher blood alcohol in a person weighing 100 pounds than in a person weighing 200 pounds. The late Dr. Raymond Pearl of Johns Hopkins Medical School reported that moderate drinkers live as long as do total abstainers. On the other hand, heavy or so-called excessive drinkers shorten their life span, evidently through the action of alcohol. As regards the immediate and temporary action of alcohol (the degree of inebriety) there are considerable individual variations in tolerance. But it is not yet known whether persons having low tolerance suffer chronic injury more readily. All that can be said at present is that to the average normal adult possible chronic injuries from the amounts of alcohol mentioned have not yet been proved or clearly separated from hereditary factors in the organ potentials, from the inevitable effects of disease, from accidents, from the strain of living and from the aging processes."

Another *Journal* consultant, reviewing the effects of the moderate use of alcohol, states: "One of the best sources of data concerning the effects of the moderate use of alcohol is that offered by the statistical studies made in the Medico-Actuarial Mortality Investigation, carried out by a Joint Committee of the Actuarial Society of America and the Association of Life Insurance Directors. The published reports in 1914 and again in 1929 consisted of a study of over 2,000,000 policies. In this investigation the term 'moderate drinker' was applied to persons who took an average of two glasses of beer or one glass of whisky or their equivalent daily. Of this group the better class of risks, those who were accepted at the standard rates of premium, indicated a mortality of 15 per cent higher than the average of all insured lives treated as standard risks, i.e. a relative mortality of 115 per cent. It is pointed out however that, while the habits were recorded at the time of application, the higher mortality than usual may be due largely to a proportion of the applicants becoming immoderate drinkers at a later date. The death rate in this group was higher than the normal from cirrhosis of the liver, cerebral hemorrhage and pneumonia.

"By comparison, whereas some members of the 'moderate drinker' group were allowed policies at the normal rate of premium, another group, which consisted of those who drank to excess not oftener than three times a year but whose bouts lasted two or three days at a time, were considered as distinctly hazardous risks, with a relative mortality of 331 per cent."

FINAL EDITION OF "COURAGE AND DEVOTION BEYOND THE CALL OF DUTY"

The final edition of the book, "Courage and Devotion Beyond the Call of Duty," which is composed of official awards and citations received by U. S. medical officers during World War II, is now being prepared by Mead Johnson & Company, Evansville, Indiana.

Any physician, who has not already done so, should write to Mead Johnson & Co. advising them of the awards he has received and also send a typewritten or photostatic copy of his citations. Also: Present rank or rank at time of discharge; branch of service; from what university and in what year M.D. degree was received; date of entry into the service.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA

By FREDERICK N. SCATENA, M.D.
Secretary-Treasurer

Board Proceedings

The Board of Medical Examiners met at the Mayfair Hotel in Los Angeles, August 25 to 28, 1947. Written examinations were conducted for 93 applicants for physician's and surgeon's certificates and two for chiropody certificates.

The following changes were made in the status of licentiates of the Board at the meeting held on the above mentioned dates:

Monte Salvin, M.D.—Found guilty of the charges set forth in the accusation and his license was revoked.

Robert P. Stock, M.D.—Found guilty of the charges set forth in the accusation and his license was revoked,

In conformance with a recent amendment to section 2147.5 of the Business and Professions Code the Board approved for residencies those hospitals that meet unconditionally the minimum requirements for general standardization set by the American College of Surgeons.

As a matter of information it should be understood that graduates of approved Canadian schools, while not designated as graduates of foreign medical schools by the Business and Professions Code at the present time, cannot apply for a reciprocity certificate unless they hold a license issued by some other state of the United States. They must take the regular written examination. Further the Code between September 15, 1935 and September 19, 1939 did designate Canadian schools as foreign medical schools. Therefore an applicant applying for reciprocity who was issued a license by some other state of the United States between the above mentioned dates, must meet the additional requirements of foreign medical school graduates should he apply for reciprocity.

WATER BORNE DISEASES NOW AT THEIR LOWEST POINT IN U. S. HISTORY

Water borne diseases in general in the United States are now at their lowest point in our history, as the result obviously of the combined efforts of engineering and medical officials over the last half century, states a medical consultant in answer to a query in the July 19 issue of *The Journal of the American Medical Association.*

The sewage of somewhat more than 50 per cent of the total urban population of the United States is now treated before it is dumped into surface waters, he states, either by what is known as partial treatment or by complete treatment.

The Journal consultant points out that "the practice of discharging raw sewage has been continued not only because of the cost involved but because of a variety of complex legal, administrative and fiscal issues. Cost is a significant item in these considerations, but not the only item. Progress in correcting this situation has been materially retarded during the war period and in the present high level costs of labor and materials, in the postwar period."

He adds that "administrative attack on the problem, however, continues at a high level and it may be anticipated that the next 10 years will see billions of dollars expended in correcting the situation."

PNEUMONIA IMMUNIZATION CUTS DEATH RATE OF OLDER PERSONS

A group of New York investigators, who made a six-year study of pneumonia in elderly patients, suggest immunization against the disease where high incidence rates prevail, as in epidemics, in institutions and in persons with a tendency to recurring pneumonia.

Writing in the current issue of the *Archives of Internal Medicine,* published by the American Medical Association, the investigators—Paul Kaufman, M.D., Attending Physician, Goldwater Memorial Hospital and New York City Home, C. O'Brien, M.D., Resident Physician and H. Stein, M.D., Resident Physician, New York City Home—state that they undertook their study in the older age group for several reasons:

First, they have a high incidence of pneumonia, mortality and case fatality rate. Second, repeated attacks of pneumonia occur frequently. Third, there was possibility for continuous observation, hospitalization and reexamination, since the patients were from the New York City Home and the Medical Division of the former Central and Neurological Hospital and the Goldwater Memorial Hospital, where higher age groups are treated.

During the six-year study , 1937-1943, 5,750 patients were immunized against pneumonia while 5,153 control patients were observed for comparison. Among the immunized group 99 developed pneumonia, an incidence rate of 17.2 per 1,000, of which 40 died, a mortality rate of 6.2 per 1,000. There were 227 cases of pneumonia among the non-immunized patients, an incidence rate of 44 per 1,000, with 98 deaths, a mortality rate of 19 per 1,000.

The antigen used in these experiments for immunization is made from a fraction of the pneumococcus, the organism responsible for pneumonia. The antigen, which incites production by the body cells of a substance to fight the bacteria, is a polysaccharide.

MOSQUITO CONTROL REPORTS ON SUBVENTION PROGRAM

Of the $400,000 available for subventions to local mosquito abatement districts during the 1945-47 biennium, $395,425.48 were expended.

It is estimated that during this period, approximately $3,000,000 was used from local, state and federal funds for mosquito control in California.

Districts which received subvention funds from this department have a total area of 8,963 square miles.

During this period a great expansion occurred in the area covered by mosquito abatement districts. This information can be summarized as follows:

	Square miles
Total area in mosquito abatement districts before 1945	7,616
Annexations and new districts since 1945	5,233
Total area in districts, June 30, 1947	12,849

It is estimated that an additional 5,000 square miles may be eventually included in mosquito control work by formation of new districts and annexations to already formed districts.

California's mosquito control subvention program was started in 1946 when the State Legislature enacted a bill to provide state assistance of local agencies for the control of disease bearing mosquitoes on a 50 per cent matching basis. This department was authorized at that time to enter into cooperative agreements with any local district or other public agency engaged in the work of controlling mosquitoes.

(Continued on Page 60)

MOSQUITO CONTROL REPORTS ON SUBVENTION PROGRAM

(Continued from Page 58)

In applying for funds a district is required to submit a statement on the prevalence of malaria and human and equine encephalitis, to prepare a map showing cases during the preceding five years and the proposed disease-control area, to present a budget and to state the qualifications of the person having technical responsibility for the program.

The work of the Mosquito Control Section in its relationships with local mosquito abatement districts forms only one part of the Department's mosquito-borne disease control activities. For an analysis of the entire program, readers are referred to the July, 1947, issue of *California Medicine*, page 28 of which contains an article "California's Plan for the Study and Control of Mosquito-borne Diseases" by Dr. Lester Breslow and Mr. Arve Dahl of this Department.—From *California Health*, published by the California Department of Public Health.

FIND COMBINATION OF DRUGS EFFECTIVE FOR ULCERATIVE COLITIS

Patients with chronic ulcerative colitis, an infectious disease of the large intestine, were effectively treated with penicillin taken by mouth and an intestinal sulfonamide, phthalylsulfathiazole, according to Michael M. Streicher, M.D., of Chicago.

Writing in the May 24 issue of *The Journal of the American Medical Association*, Dr. Streicher, who is assistant professor of medicine, University of Illinois College of Medicine, treated 45 patients with this disease.

The author points out that the combination of drugs was very effective because such infectious agents as the staphylococcus, which is responsible for boils and the streptococcus, which causes "strep" throat, are present in the intestines in ulcerative colitis. . . .